NUTRITION REFERRALS TO
THE DURHAM COUNTY HEALTH DEPARTMENT

Procedures for making nutrition referrals are:

- Mail or fax nutrition referral form to the Health Department. For faxed referrals, the original referral must follow by mail. Referrals can be made by anyone, however, referrals for nutrition counseling for medical conditions such as diabetes, hypertension, etc. needs to be completed and signed by the primary medical care provider. Referrals for nutrition counseling for diabetes and renal disease under Medicare Part B benefits must be signed by the treating physician.

- Upon receipt of the referral, clients will be contacted by the Nutrition Division to schedule a nutrition visit at the Health Department or at the client's home.

- After the nutrition visit, the nutritionist will send a summary of the nutrition encounter to the referring provider.

- Subsequent nutrition visits will be scheduled as needed by the nutritionist and client.

- Fees for nutrition services are based on a sliding scale fee. Medicaid, Medicare Part B and Health Choice may be billed for certain nutrition services.

The Nutrition Division is staffed with licensed dietitians/nutritionists who specialize in nutrition care for children with special needs, general pediatrics, obstetrics, chronic disease, HIV/AIDS and geriatrics.

For more information or questions call the Nutrition Division at 560-7791 or Michele Easterling, Clinical Nutrition Team Leader at 560-7784.

Examples of conditions which may indicate a need for nutrition assessment and/or counseling:

✓Inappropriate growth/weight loss/gain *such as* inadequate weight gain, inappropriate weight loss, underweight, excessive weight gain, overweight/obesity, inadequate linear growth or short stature, failure to thrive
✓Low hemoglobin/hemocrit
✓Elevated lead level ($\geq$ 15 mg/dl)
✓Eating or feeding problems, including eating disorders
✓Chronic constipation
✓Physical conditions which impact on growth and feeding such as very low birth weight, necrotizing enterocolitis, cleft palate, cerebral palsy and neural tube defects
✓Chronic or prolonged infections that have a nutritional component *such as* HIV, hepatitis
✓Genetic conditions that impact on growth and feeding such as cystic fibrosis, Prader-Willi Syndrome, Down Syndrome
✓Chronic medical conditions *such as* cancer, chronic or congenital cardiac disease, diabetes mellitus, hypertension, hyperlipidemia, gastrointestinal diseases, liver disease, malabsorption syndromes, pulmonary disease, renal disease, significant food allergies and diseases of the immune system
✓Pregnancy, especially with the following conditions:

-Severe anemia
-Preconceptionally underweight
-Inadequate weight gain during pregnancy
-Intrauterine growth retardation
-Multiple fetuses
-Substance abuse

✓Other, including parent/caregiver requests nutrition visit

Pediatric ☐Parent/Guardian notified of referral_____initial/date

MEDICAL NUTRITION THERAPY REFERRAL
DURHAM COUNTY HEALTH DEPARTMENT

Fax or mail to Durham County Health Department, Nutrition Services, 414 East Main Street, Durham, NC 27701 ◆ 919/560-7791 fax 919/560-7786

For faxed referrals, original referral must follow by mail.

Patient_____DOB____/____/____ SS # _____
Name of parent/guardian_____ Phone_____
Gender: M F Language: ☐ English ☐ Spanish ☐ Other,_____
Address_____
Directions to home (*when applicable*)_____
_____
Reimbursement Source: (*check all that apply*) ☐ Medicaid ☐ Health Choice ☐ Private Insurance
☐ Uninsured. Policy No:_____
Patient may be responsible for charges not covered by insurance.

Referral Information: *Completed by person making referral; please include all applicable information. Referral for nutrition counseling for medical conditions such as diabetes, hypertension, etc. must be completed by treating provider.*

Reason for Referral_____
Diagnoses_____
ICD-9 code(s)_____*Indicate ICD code to highest level of specificity*
Relevant labs/other data_____(date/s)
Height/length_____Weight_____ (date)_____
BMI-for-age percentile_____Birth weight_____Gestational age:_____
Please include copies of growth charts when applicable.
Medications_____
Nutrition Order: ❑ dietitian to evaluate & formulate ❑ other, *specify*_____
_____
Expected nutrition outcome_____
Exercise restrictions___no ____yes, *specify*_____
Referral Date_____ Provider completing referral/phone_____
Patient's Physician (*signature*)_____
Physician name (*please print*)_____UPIN #_____
Address_____Phone_____Fax_____

Additional Information:

For nutrition office use only: *1)*_____ ❑ pc *2)* _____ ❑ pc
3) _____ ❑ pc *4)* _____ ❑ pc
DCHD #_____Fee Status _____ %

5/03 pc = reminder postcard sent to patient